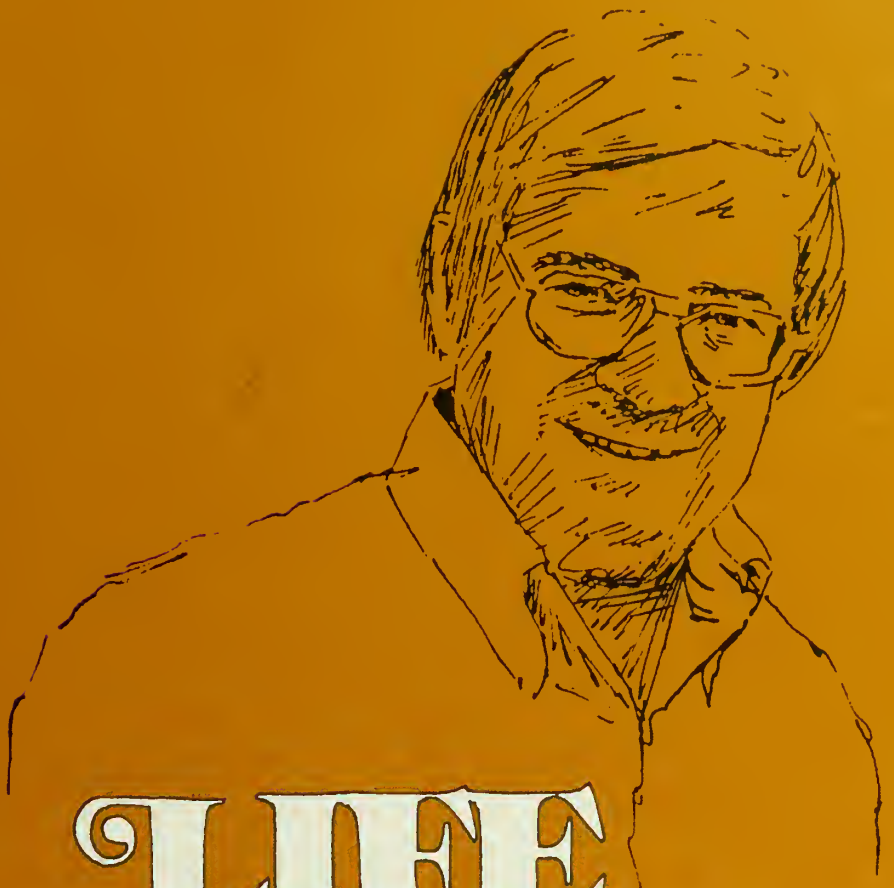
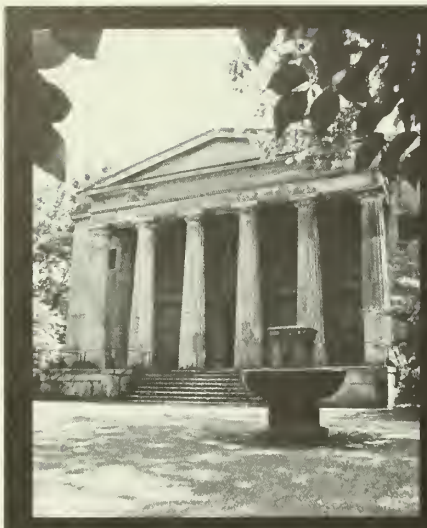
# MCG Today

Medical College of Georgia, Fall 1977, Vol. 6 No. 4



# LIFE AFTER LIFE

RAYMOND A. MOODY, JR., M.D.




# MCG Today

## Medical College of Georgia
## Fall, 1977 Volume 6, Number 4

MGC Today is published quarterly for alumni and friends by the Medical College of Georgia, Division of Institutional Relations. Correspondence is invited and may be addressed to 1120 Fifteenth Street, Augusta, Georgia 30901. Second Class postage paid in Augusta, Georgia.

**Classnotes Editors**

Mary Glennan (Medical Record Administration); Jessie O. Brown (Dental Hygiene); Octavia Garlington (Medical Illustration); Susan Martin (Medicine); Susan McCord (Radiologic Technology); Mary Thompson (Nursing); Ruth Winningham (Medical Technology).

**James. C. Austin**
Executive Editor

**Donald G. Nichols**
Managing Editor

**Garon Hart**
Art Editor

**Editorial Staff**

Alex H. Vaughn
Julie Guillebeau
Laurence Christensen
Richard Crabbe
Doug Vinson


# Inside

*MCG students receive experience through MECO—Medical Education Community Orientation program while providing needed service to underserviced areas. First year medical students Michael Evans and Jenny Hawkins spent ten weeks this summer in Sylvania, Ga.* **See Page 24.**

*There is an old fable that tells how the young Indian brave, True Vision, trapped death. Writer Richard Crabbe captures the feeling of what it's like for a doctor to tell his patient that he will die.* **See Page 14.**

*The initials 'AMA' take on an instantaneous meaning for the vast majority of alumni, friends and faculty of the Medical College of Georgia. "American Medical Association, of course!" you'd say. Recently, 'AMA' has taken on another meaning for administrators of MCG.* **See Page 7.**

*Why would a boy coming from a farm in Kite, Georgia, who today is among the best respected vascular surgeons in the Southeast, be so concerned about endowment at the Medical College of Georgia?* **See Page 26.**

### On the cover:

MCG alumnus Dr. Raymond A. Moody, Jr. has an estimated thirty million people aware of his medical research as a result of authoring the bestseller Life After Life.

# Behind the Lines

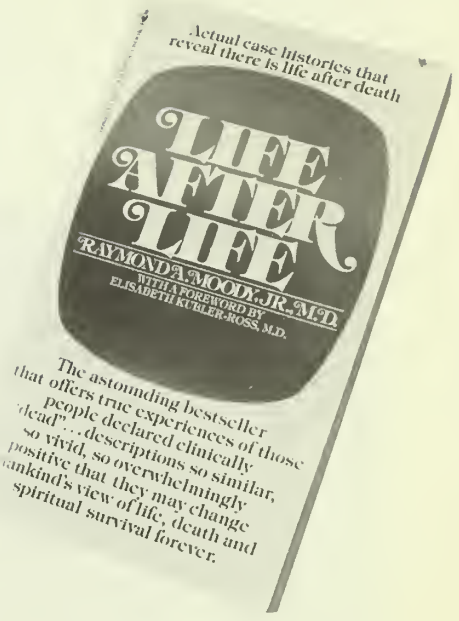
**By James C. Austin**
*Executive Director*
*Medical College of Georgia Foundation*

Following are some important facts you should know about MCG's Sesquicentennial (150 years) Endowment Fund Campaign. We believe this information clearly summarizes why MCG needs and deserves your financial support.

1. The Medical College of Georgia will celebrate its 150th anniversary on December 20, 1978. It is the eleventh oldest medical school in the United States.
2. Current enrollment totals 2,700 students in all five schools. Just ten short years ago enrollment was slightly over 600.
3. For the first time, four years ago, MCG began to build an endowment fund. This fund will help to make MCG more competitive in the educational marketplace. MCG is finding it difficulty to compete for talented faculty with such handsomely endowed schools as Harvard, Duke, Miami, Baylor, Emory, North Carolina, and Johns Hopkins—to name just a few.
4. The Sesquicentennial Endowment Fund is one of many funds administered by the MCG Foundation. The Foundation is a tax-exempt, nonprofit corporation established in 1954 to provide financial support for MCG in cases where state allocations are insufficient to do an adequate job.
5. Many people think, erroneously, that MCG receives all of its operating funds from the state tax money. Actually, only 48 percent of MCG's $70 million operating budget comes from state allocation. The remainder must be generated internally through grants, contracts, patient fees, services such as bookstore and cafeteria, and from ENDOWMENT.
6. MCG presently ranks near the bottom of the list among medical schools in the Southeast as regards salary and student-faculty ratio. Most medical students have the benefit of at least a one to one ratio with their faculty. At MCG, this ratio is closer to two students to one faculty member.
7. The immediate goal of the MCG Sesquicentennial Endowment Fund is $3 million in cash and pledges by December, 1978. To date, MCG is only halfway to its goal. MCG is looking to its alumni (7,500) for $1 million and to corporations, foundations, and non-alumni friends for $2 million.
8. During the past three years, while the economic crunch hit not only business and industry but also state government (including faculty salaries at MCG), we lost many fine faculty members to other medical schools who were sufficiently endowed to offer salary supplements to our professors. MCG lost because it did not have sufficient endowment funds to provide the financial flexibility needed to compete with these other schools.

If there are any questions, or if you need additional information about the MCG Sesquicentennial Endowment Fund Campaign, please contact either Don Nichols, Associate Director for Development or Jim Austin, Director of Institutional Relations at MCG, (404) 828-2515, or write Sesquicentennial Fund, MCG Foundation, Alumni-Foundation Center, Medical College of Georgia, Augusta, Georgia 30901.

**Dr. Raymond A. Moody, Jr.**
**Author of best seller, Life After Life**


Actual case histories that reveal there is life after death
LIFE AFTER LIFE
RAYMOND A. MOODY, JR., M.D.
WITH A FOREWORD BY ELISABETH KÜBLER-ROSS, M.D.
The astounding bestseller that offers true experiences of those people declared clinically "dead"...descriptions so similar, so vivid, so overwhelmingly positive that they may change mankind's view of life, death and spiritual survival forever.

**By Doug Vinson**

Medical College of Georgia alumnus Dr. Raymond A. Moody, Jr. has an estimated 30,000,000 people currently aware of his medical research.

The subject that elicited this phenomenal public response, the experiences of persons who were resusitated after being clinically dead, attracted Moody's interest over eight years ago. His publication of his findings began with a lecture to the Milton Anthony Society, proceeded as a published article, and 150 case studies later the information was incorporated into the bestselling book *Life After Life.* Currently it is in its 18th printing. Several months ago the *Reader's Digest* presented it as a condensed book. In the past several months, Dr. Moody has lectured frequently in all parts of the country to various civic, church and medical groups. Television interviews with Merv Griffin and others reached a wide national audience. Nor does interest appear to be lagging. An edition of 250,000 copies, about two-and-a-half times the number it takes to make the best seller list, will shortly be released in West Germany.

His second book *Reflections on Life After Life,* which was written in response to the hundreds of questions he has been asked while giving lectures, is also doing quite well.

Having read both books with great interest the writer of this interview recently flew to Charlottesville to see what kind of man was responsible for this storm of interest. The interviewer found Ray Moody, who is now on the faculty of the University of Virginia in the philosophy department, an unassuming scholar, as unimpressed with his fame as he is fascinated with the frontiers of medical research. He is a native of Georgia born in Porterdale, and his wife Louise is from Macon. His father, Raymond A. Moody, Sr. is a surgeon in Macon and also a graduate of the Medical College of Georgia.

Despite this background Raymond Jr. did not immediately decide on a medical career. A man of wide ranging interests, he began his college work with a career in astronomy in mind. Later he earned a Ph.D. in Philosophy from the University of Virginia in 1969 and taught that subject on a college level for three years. At that point he decided to go to medical school.

He chose the Medical College of Georgia and he completed his degree in 1976. Reflecting on his student days Moody has high praise for the emphasis on clinical work and the uniformly high quality of the instruction he received. "There were many teachers that were excellent, but I particularly enjoyed the courses I had under Dr. Rene Cormier, Dr. Joe Bailey, Dr. Malcolm Page and Dr. Claude Star Wright," says Dr. Moody.

In writing his book Dr. Moody says he benefited greatly from the comments and suggestions he received from many people at MCG, especially Dr. Russell Moores, Dr. Richard Martin and Dr. Ed McCrainie.

Dr. Moody's careful scientific approach to a topic that lends itself to sensationalism is refreshing. His low key, objective approach throughout the book enhances the credibility of the amazing accounts he collected and recorded.

"I am disappointed that the front cover of the book defines my work as 'Actual case histories that reveal there is life after death,'" says Dr. Moody.

The MCG alumni stressed many times during our conversation as he does in his book that he is not attempting to prove a thesis and did not feel his work, to this point has "established definitive scientific evidence of the existence of life after death". He is disturbed by the inaccurate, interpretative enthusiasm applied to his work by headline writers and book reviewers in more than a few cases.

When asked what particular satisfaction his study had brought

him, he said he was glad to have a part in the "establishment of a virtually undocumented area of human experience".

"I am gratified by the response in this subject on the part of other concerned individuals who are now investigating this phenomena. Also, people generally seem more open and more willing to think about the implications of the study," says Dr. Moody.

Asked what his next step in this research would be he gave the surprising answer that he does not plan at present to continue work on it, although he is following the work of others with keen interest.

Indeed one can not but be impressed by Moody's modest unconcern with the fame he has achieved and disinterest in the possibilities of commercial exploitation it might offer.

Dr. Moody talks with more interest about taking up new challenges in medical research than dwelling on his considerable accomplishments.

After January 1 he intends to give no more lectures on the life after life research. "In September I will give a seminar exploring possible applications of humor to some aspects of medicine. This has nothing to do with jokes about doctors and their indecipherable handwriting," says Dr. Moody with a smile. Dr. Moody says he plans to study the psychological and therapeutic value of humor in overcoming illness.

His evident wit and insight seem ample guarantees that his research and seminars will avoid the utterly deadly serious analysis of humor that literary students of the subject seem inevitably to produce.

His professional and personal goals are contrary to what might be expected of so successful a young man. He wants to live in a small town or rural area and devote much of his time to general medical practice. Devoted to his wife and two young sons he is the kind of father who has taken his six year old to see Star Wars four times.

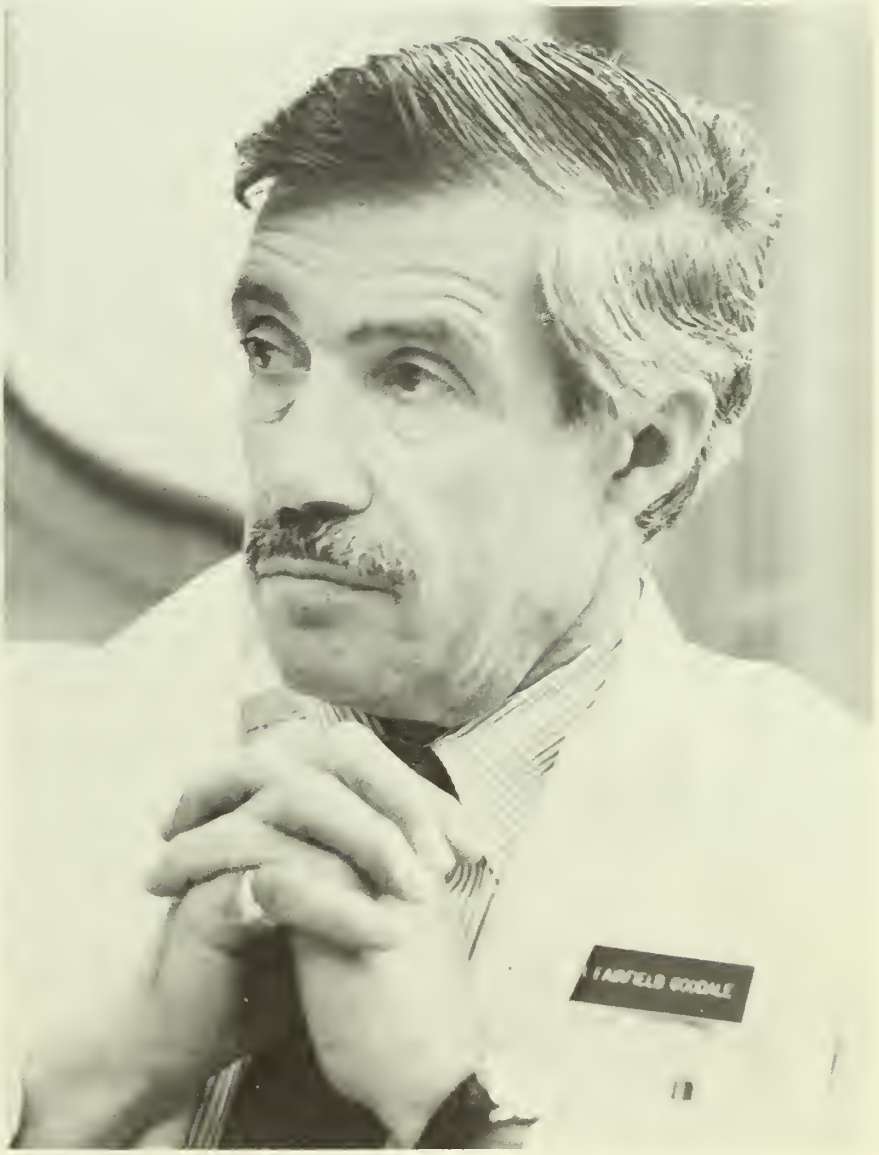
He talks with enthusiasm of getting away from public demands, spending more time with his family, taking up farming and relaxing in a rocking chair.

"I am really looking forward to getting back to my interests in medicine and psychiatry," says Dr. Moody.

Frequently during our interview Dr. Moody recalled the sound training and inspiration that MCG faculty afforded him during his student days. MCG is proud of Dr. Moody's accomplishments. It was a pleasure to observe that he reciprocates the feeling.

# Practical Cogitations

**By Fairfield Goodale, M.D.**
**Dean, School of Medicine**




*Editor's Note: Following is the text of the commencement address delivered by Fairfield Goodale, M.D., dean of the School of Medicine, at MCG's June 11, 1977 graduation exercises.*

When this address to the graduating classes was first mentioned to me some weeks ago, it was prosposed that it be a message. Now, the Oxford Dictionary definition of the word "message" includes brevity and also, as one of its meanings, defines it as a Prophet's Inspired Communication. Brief, I can be.

But, as you know, Prophets are presently in very short supply, to say nothing of Inspired Communications. So, with those constraints understood, I have collected a few personal observations, biases and beliefs into a short dialogue. In so doing, I proceed with appropriate apprehension, along somewhat the same paths as heroes of mine like Benjamin Franklin and his *Poor Richard's Almanac*, and Lord Chesterfield, in *Letters to His Son.*

At the very outset, two things must be said.

First, and most obvious, I want to extend to each of you my deep-felt congratulations. You are special people, you have made a special effort to get here, and you will do a special job wherever you are going. We are very proud of you.

Second, I do not propose to discuss timely topics such as the Cost of Health Care, the Siren Song of Certain Contraception, or the effects of saccharin on the bladders of unborn mice.

Rather, I will concentrate on personal attributes—with no special concern for those commonplace virtues, which, naturally, we all possess, but with particular emphasis on a few less often mentioned but equally valuable qualities.

Let me then launch this frail craft of beliefs and cogitations, remembering that no mariner ever distinguished himself on a smooth sea.

Sometimes, I beg you to be unreasonable. The unreasonable man persists in trying to shape the world to himself. Therefore, most progress depends on the unreasonable man. So often however, this involvement requires the courage to be heard, the courage to take a stand, the courage to avoid the role of bystander, though the issue be unpopular, though appeasement is easy, though silence be expedient. Ofttimes, the appearance of courage is as important as the substance of courage.

Resolve to make no small plans. They will stir no one, least of all yourself, and your world will be diminished accordingly, far better it is to form big plans, exciting plans, plans with a vision. And even though risks there may be, accept them gracefully. To dare splendid things, you will certainly court failure, but how much better that, than to dwell in a twilight that knows neither victory nor defeat.

Reach, always, for the best there is. Few of us achieve the levels of excellence of which we are capable. So much there is to see and to do along the way, so much applause for second- and third-rate achievements, that to settle for mediocrity is all too easy. Sooner or later, however, humanity turns to excellence as naturally as a flower turns to the sun. Socrates was executed, Christ was crucified, but in the end, they received the homage of the world.

Choose carefully your friends, value them highly. The size of a friend can be measured by the size of the circles he draws to take the world in. Some of us are too small to draw a circle much bigger than ourselves; but others of us, wiser, and stronger, build enormous circles which are filled with light and warmth and love and all manner of friends.

Understand the implications of your beliefs. It is the ability of an educated person to move from hypotheses to consequences, from discipline to discipline, from process to content.

If you will, try to listen more and talk less. One learns nothing by talking and only you who listen have something worthwhile to say. At the same time be sparing with advice. The wise don't need it, the others won't listen.

Enjoy your own company beyond that of others. Nowhere will you find a quieter or more untroubled haven than within yourself. Knowledge of yourself is the only real wealth there is and from it comes strength and peace and self-confidence. Self-confidence may not always get a person to the top, but no one ever got there without it.

Strive unceasingly to be a Futurist. Living each day as it comes is grand as long as it includes planning for tomorrow. Surprises tend to be unpleasant and unproductive and their shock can generally be avoided by anticipation.

Lastly, human life is a brief, golden span between two oblivions, starting as a miracle, ending in mystery. In between are varying degrees of happiness and frustration, of fulfillment and anxiety, of joy and pain.

To each of you graduates has been given the unique privilege of life-long service for the betterment of the human condition. In the words of Oliver Wendell Holmes: To cure seldom, to relieve often, to comfort always. This is your challenge.

Thank you.

# "AMA" takes on new meaning for administrators

**By Linda Wilson**

Operating a health science university with five schools, over 2600 students, 550 full-time faculty, a large teaching hospital, numerous out-patient clinics, 4,000 plus employes, and a budget of 75 million dollars is not an easy job.

Like any "big business," a college needs a long-range plan. Goals must be explicitly stated, objectives measurable and employes and administrators accountable.

As president of MCG, Dr. William H. Moretz has recognized the need for a professional management approach at all levels of the College's administration. His awareness of this need was sharpened when he attended, at the suggestion of Mr. Gerald Achenbach, chairman of the board of Piggly Wiggly Southern, Inc. and chairman of the President's Advisory Council, a management training session conducted by the American Management Association (AMA). As a result of this meeting, Dr. Moretz requested the AMA to formulate a proposal for installing a modern management system at MCG.

The AMA responded to the request with a multi-phased program—a program designed to orient approximately 200 administrators in modern management approaches to aid in the development of a set of long-range plans and management programs for the College. The overall plan calls for four phases and stages I and II are currently in progress.

During the month of September, three 3-day management training sessions were held at lodge at nearby Clark Hill Lake. They were attended by administrators from middle and top management levels. The purpose of Phase I was to develop an awareness and appreciation for modern management techniques, paving the way for the middle managers to work effectively with top management in developing and implementing a total management system.

Phase II of the project called for the Senior Advisory Group, plus a representative of the faculty and the institutional coordinator for the management program (Dr. Kenneth Morse) to have two 5-day planning sessions at the AMA Planning Center in Hamilton, New York. During the week of the first session, with the aid of management consultant Dr. John Goode, the management team developed a statement of mission, goals, and specific objectives. They also performed a situational and environmental analysis.

The published results of the meeting, the "Hamilton Papers", have been shared with the faculty for their imput and refinement. The faculty, working through a Faculty Senate committee has responded in writing on a point-by-point basis to the material in the Hamilton Papers.

During the second Hamilton meeting, the group is scheduled to select specific strategies to meet the previously formulated objectives and to develop action plans and control systems to assure their achievement.

Phase III of the AMA project overlaps chronologically with the second phase and calls for eight days of visits by management consultant Dr. John Goode of Chapel Hill, N. C. Dr. Goode will help with the refining of the preliminary plans and begining the necessary action plans and controls.

The ultimate purpose of this program is to develop and implement an effective management program for the Medical College. Basically, its aim is to identify organization priorities and key policies, select the appropriate strategies for reaching these objectives and develop strategies to insure success. But to be successful, accountability must be established for individuals and for programs and performance must be measured against stated objectives. This is an integral part of the overall project, as is the plan for installing control systems to bring performance into line with the objectives and the developing of an in-house training capability.

MCG's top managers are strongly committed to this program. Dr. Moretz and the Senior Advisory Council feel it represents a prime strategy for achieving better administration at the Medical College; and, the President's Advisory Council has expressed its faith in the project by underwriting some $20,000 of the cost. In addition to the financial commitment, the Medical College is making a time commitment of an estimated 3.4 man-years of managerial time to receive the necessary training and to conduct the preliminary planning.

MCG's participation in the AMA project also may have fringe benefits. This probably represents the first time an entire health institution has approached professional management on such a large scale. As such, the College gains an opportunity to serve as a model for other institutions that might seek to follow in its footsteps. A historical record will be kept of the various documents memoranda, etc. created in the process of developing and implementing the plan. It is hoped that this documentation will be helpful in describing the genesis and development of such a project and in drawing implications for the potential benefit of other institutions.

# campus news

## Orville A. Parkes dies following brief illness

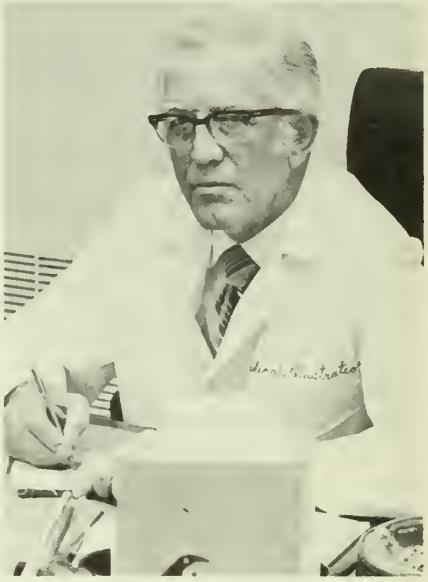
Orville A. Parkes, professor emeritus and former chairman of medical illustration at the Medical College of Georgia died Sept. 26, 1977 after a brief illness. He was 71.

Parkes came to MCG in 1949 as professor and chairman of medical illustration. He retired from active teaching in 1974. When he arrived on campus, there was one medical illustration student. Today, there are 17. In 1973 the program was cited as outstanding by the accreditation committee of the Southern Association of Colleges and Universities. It was the first such program to be accredited by the Board of Governors of the Association of Medical Illustration.

He earned a BA degree from Augusta College, after studying at Johns Hopkins University, Baltimore, under Max Broedel, recognized as the father of medical illustration in the United States.

His medical illustrations appear in numerous medical textbooks and journals.

Graveside services were held in Augusta. Memorial contributions may be made to the Orville Parkes Endowment Fund. Checks should be made payable to MCG Foundation "Orville Parkes Fund." Mailing address: MCG Foundation, c/o O. A. Parkes Fund, Rm. AA139, Medical College of Georgia, Augusta, Ga. 30901.



*Orville A. Parkes*

**Karen Meisel**

Karen Meisel, (class of '74), Occupational Therapist, Mississippi Methodist Rehabilitation Center, presented a paper at the National Occupational Therapy Association meeting in San Juan, Puerto Rico.

Meisel has researched ways occupational therapy professionals can participate in health care planning for service delivery and identifying occupational therapists as manpower that should be utilized in providing total health care.

Another honor received by Meisel is her recent election as president of the Mississippi Occupational Therapy Association.

*Karen Meisel*

*Dr. Paul Webster*

**Chairman appointed**

Dr. Paul D. Webster has been appointed chairman of the Medical College department of medicine.

Dr. Webster has been associated with MCG since 1968, serving as professor of gastroenterology and as chief of staff at the Forest Hills Division of the Augusta Veterans' Administration Hospital.

A graduate of the University of Richmond and Wake Forest University's Bowman Gray School of Medicine, Dr. Webster serves on the editorial boards of several professional journals and has received awards for his work at the VA Hospital as a clinical and medical investigator.

**Class of '47 reunites**

Dr. William H. Houston is making arrangements for the 30th reunion of the School of Medicine Class of '47. The reunion will be held November 19, 1977 during the MAG meeting in Atlanta. Contact Dr. Houston: 441 Marshall Tylor Building, Jacksonville, Fla. 32207 for details.

**Huisman named**

Dr. Titus H. J. Huisman has been named chairman of the MCG department of cell and molecular biology.

Dr. Huisman joined the Medical College faculty in 1959 as an associate professor of biochemistry and pathology. In 1964 he was named the first Regent's professor at the college. Dr. Huisman currently serves as director of MCG's Comprehensive Sickle Cell Center and is principle investigator at the VA Hospital's Hemoglobin Laboratory.

## AHS honors day

Student achievement was recognized by departments of the School of Allied Health Sciences in June at an Honors Day Ceremony.

Recipients are as follows:

*Associated Dental Sciences,* clinical achievement award: Pamela Weaver; academic achievement award: Amanda Leonard and Becky Gattis; Julia R. Galbaugh Award in Public Health: Jannis Thurman and Craig Walker.

*AMSA-Eaton Medical Art Award,* First Award: Susan Hilfer for "GEOMETRIC TOTAL KNEE REPLACEMENT", Third Award: Patricia Berry for "RECESSION OF THE LATERAL RECTUS MUSCLE, AND RESECTION OF THE MEDIAL RECTUS MUSCLE".

*Medical Technology,* Dr. Walter L. Shepeard Achievement Award: Sharon Burruss and Sharon Sears; Frances Bartlett Scholarship: Janis Gatlin.

Members of this year's Student Bowl Team were Sharon Burruss, Lorraine Okuma, Sharon Sears, Peggy Torcivia and Beth Raines.

*Radiologic Technologies,* Outstanding Student Awards were presented to Thomas R. McDonald and Marcus Alan Gilbert.

Student achievement was also recognized at an Honors Day Ceremony in September. The Outstanding Student Award in Radiologic Technologies was presented to Sara Martin and William Gregory Long.

The Department of Respiratory Therapy presented the Chairman's Award to Edith Stassi.

The Alpha Eta Honor Society accepted for membership the following students from both June and September graduating classes:

Paula Dianne Garrison
Becky Kay Gattis
Amanda Gail Leonard
Pamela Joyce Weaver
Joel W. Geisinger
Patricial Ann Barry
Carla Ann Rabun
Sharon Marcinko Burruss
Peggy Gay Torcivia
Bendel L. Rucker
Maralynne D. Mitcham
Raymond Kurker
Harry Tinley Reynolds
Allen R. Black
Johnny T. Cummings
Ellen S. Gilbert
Teresa A. Scholly
Timothy M. Sullivan

*Honors Day award recipients L-R Sharon, Burruss, Sharon Sears and Patricia Barry*

# Health Philantropy and Public Policy.

By Walter J. Unger

*EDITOR'S NOTE: The following article comes from an address delivered earlier this year at the University of Chicago Center for Continuing Education's fifth national fund raising conference.*

If you have been engaged in some way with raising funds for health projects for very long you are probably keenly aware of two major trends:

1) From a financial viewpoint, the importance of philanthropy in the health field is declining.
2) The federal government's participation in health care financing is dramatically expanding.

It would be foolish for me to predict that these trends will change over the next decade, even though some of you may wish to hear otherwise. The prospect, as I see it, will be one of a continuing expansion of the federal government's role in the health field.

If you accept this—and understand its consequences—there should be no need for despair about your future. *Philanthropy will continue to play a significant role in the health field;* however, its role in the future will be different than its role in the past. But before looking ahead, let's look back at what has happened.

According to the American Association of Fund-Raising Counsel, the health field is the second largest recipient of philanthropic giving. Only religious causes receive more than health causes.

The distribution of all philanthropy by field looks like this:

43% goes to religion
16% to health
15% to education
9% to social welfare, and
17% to other purposes.

Total giving to health causes amounted to $3.9 billion in 1974, nearly double the $2.1 billion contributed a decade earlier. During this same period, giving to all causes slightly more than doubled—growing from $12 billion to $25 billion.

**Health philanthropy declines**

Thus, health philanthropy when compared to total philanthropy has suffered a small decline over the past ten years. At the beginning of the decade, health causes attracted 17% to 18% of all philanthropy, while at the end of the decade, health causes received only 15% to 16% of all philanthropy. Each percentage point drop represents a loss to health philanthropy of more than $250 million annually.

In short, today's donors—in the aggregate—place a high value on health causes, although slightly less than donor's did a decade ago.

But even though health philanthropy is substantial—amounting to more than $4 billion annually now—and even though health philanthropy has been growing at roughly 7% per year, it represents a declining share of our national health care expenditures. The reason is simple: over the last decade, total health care spending has increased at an average annual rate of almost 12 percent.

Last year, our total spending on health care as a nation was *$139 billion,* more than *three times* what we spent a decade earlier and *double* what we spent in 1970. Consequently, health philanthropy was only 3% of total health care spending last year compared to 5% a decade ago.

On the other hand, health care expenditures by the federal government and by private health insurance have increased dramatically.

As recently as 1930, philanthropic expenditures in support of health and health-related activities nearly equalled the combined expenditures of the federal government's health programs. Private health insurance was practically non-existent.

*About the author*

*Mr. Walter J. Unger is special assistant to the president of the Institute of Medicine, an operating unit of the National Academy of Sciences, Washington, D.C. Prior to joining the Academy's staff, he was director of Planning of the University of Southern California at Los Angeles. He also served as administrator of the Good Hope Medical Foundation in Los Angeles and as a supervisor and agent for the Los Angeles Agency of the Provident Mutural Life Insurance Company.*

### Private health insurance

The concept of private health insurance did not really take hold until after World War II. By the early 50s, private health insurance was paying for about 10% of all health care expenditures. And during the last few years, it has been paying for more than one quarter of all health care costs.

But the dominant force in the health care field today is clearly the federal government. Primarily because of the medicare and medicaid financing programs introduced in the mid-1960s, the federal share of total health spending jumped from 12% in 1965 to 30% last year.

A decade ago, the federal health budget was about $6 billion; last year it totaled $42 billion, more than ten times as much as all health philanthropy.

Federal health expenditures have grown faster than other components of the federal budget. Within the past decade, they have increased from 4% to 11% of the total federal budget.

In addition, the federal government provides substantial "off-the-budget" support of the health industry by not taxing health insurance benefits provided by employers for their employees. This tax expenditure was recently estimated to amount to about $7 billion annually.

In short, the federal government has been a major stimulant of the health field. The enormous growth of this field over the past quarter century is, in my opinion, largely due to federal policies.

Our increased national priority on health is reflected, too, in our gross national product accounts. Health care spending doubled from 4.6% of our GNP in 1950 to 8.6% last year. In other words, the average American worker today works one month each year to pay health care costs. And in the future, even more of his income is likely to be spent on health care.

The average family today spends about $1,600 on health care each year—or more than 10% of the about $14,000 median family income. Yet because of the growth of third party payers, out-of-pocket expenditures for health care when adjusted for inflation have actually declined. It is not surprising then that we are "seeing the doctor" more frequently than ever before in our history.

### 4.8 million workers

To meet the demand for health services, the health care industry employs 4.8 million people, making it the largest industry in the nation. Slightly more than one American worker in 20 is employed in the health field.

There are over 375,000 physicians in practice in America: one for every 570 citizens. There are over 7,000 hospitals with a total capacity of 1.5 million beds. In addition, there are 16,000 skilled nursing homes, with a capacity of 1.2 million beds.

From these figures, you *might* conclude that health has deteriorated in this country. But to the contrary, we are *abundantly* healthy.

This is not, however, the general view of things. "The general belief these days," according to the noted scientist and author Lew Thomas, president of the famous Memorial Sloan-Kettering Cancer Center in New York City, "seems to be that the (human) body is fundamentally flawed, subject to disintegration at any moment, always on the verge of mortal disease, (and) always in need of continual monitoring and support by health-care professionals.

"This . . . new phenomenon in our society . . . can be seen most clearly in the content of television programs and, especially, television commercials, where the preponderance of material deals with the need for shoring up one's personal health. The same drift is evident in the content of the most popular magazines and in the health columns of daily newspapers. There is a public preoccupation with disease that is assuming the dimension of national obsession.

"To some extent," Dr. Thomas says, "the propaganda which feeds the obsession is a result of the well intentioned efforts by particular disease agencies to obtain public money for the support of research and care in their special fields. Every mail brings words of the imminent perils posed by multiple sclerosis, kidney disease, cancer, heart disease, cistic fibrosis, asthma, muscular dystrophy, and the rest.

### Most are abundantly healthy

"There is, regrettably, no discernible counter-propaganda. No

agencies exist for the celebration of the plain fact that most people are, in real life, abundantly healthy. No one takes public note of the truth of the matter, which is that most people in this country have a clear, unimpeded run at a longer lifetime than could have been forseen by any earlier generation . . .

"Human beings are fundamentally tough, resilient animals, marvelously made, (and) most of the time capable of getting along quite well on their own.

"We really are a quite healthy society, and we should be spending more time and energy in acknowledging this, and perhaps trying to understand why it is so. We are in some danger of becoming a nation of healthy hypochondriacs . . .

"The health care system is being overused, swamped by expectant overdemands for services that are frequently trivial or unproductive."

In increasing numbers Americans are turning to physicians simply for reassurance that they are "disease free" and for aid in a wide variety of personal maljustments including unhappiness, discontent, fear, anxiety, despair, marital discord, sexual difficulties and even educational problems. "The general public seems convinced," Dr. Thomas says, "that contemporary medicine is able to accomplish a great deal more than is in fact possible . . . *the public is not sufficiently informed of the facts about things that medicine can and cannot accomplish.* Medicine is surely not in possession of special wisdom about how to live a life."

The fundamental paradox of health care is that medical advances so often breed further needs and increase future requirements for care. The more infant lives are saved, the more serious becomes the threat of handicap. The further life expectancy is extended, the greater become the demands on geriatric services and long-term care facilities for the infirmed and elderly. Each new advance that gives hope to another category of sufferers converts a latent need into an immediate and continuing demand. Heart transplants and renal dialysis are only the most obvious examples.

On the whole, too, medical advances leave a progressively more difficult set of problems to be faced. With the conquest of infectious diseases, less tractable forms of illness such as cancer—whose causes are more complex, and whose treatment tends to be more expensive—claim proportionately more lives.

**"The health care system is being overused, swamped by expectant overdemands for services that are frequently trivial or unproductive."**

### Diminishing returns

In short, every inch of ground gained is won with greater difficulty and at higher cost than the past. It is the familar phenomenon of diminishing returns, with one vital difference: no new gain, however costly, can ever be dismissed as marginal if it promises some real reduction of human suffering. There is, in the nature of things, no possibility of saturating "demand" for the reduction of mortality and the relief of pain.

To make matters worse, there is the perverse human knack for creating new problems in the very progress of solving old ones. Mastering our environment, we endanger ourselves by polluting it. Becoming affluent, we subject ourselves to the stresses of a crowded, fast-moving world—and at the same time allow ourselves to slip into a dangerously sedentary way of life, eating, drinking, and smoking to excess. Achieving mobility, we kill and maim each other with our motor cars. Relieved of much physical ill-health, whole vistas of mental distress open before us. And when by the standards of the less fortunate, we are relatively free from definable mental or physical ill-health, we become less able than our ancestors to endure minor complaints.

Thus, in spite of many improvements in our health status, we seem to be doing better but feeling worse. As Dr. John Knowles, president of the Rockefeller Foundation, put it: "there exists a profound national concern that, despite a massive increase in health expenditures together with a marked expansion in health workers over the past decade, the nation's health has improved less than was promised or expected. The benefits have not appeared to justify the costs. To make matters worse, broad indicators of social pathology, including drug abuse, illegitimate births, divorce rates,

**The cost of sloth, gluttony, alcoholic overuse, reckless driving, and smoking is now a national responsibility.**

crime, violent behavior, learning difficulties, and psychological problems . . . tell us that the nation is not as healthy as it should be."

### Change in life style

Dr. Knowles believes that "the next major advances in the health of the American people will result from the *assumption of individual responsibility for one's own health.* This will require a change in lifestyle for the majority of Americans. The cost of sloth, gluttony, alcoholic overuse, reckless driving, and smoking is now a national responsibility. These abuses are justified on the ground of individual freedom, but one man's freedom in health is another's shackle in taxes and insurance premiums . . .

"It is now realized that there are multiple causes of disease, involving varying combinations of genetic, environmental and behavioral factors. Environmental factors include stress levels, pollutants, germs and parasites while behavioral factors include rest, smoking, exercise, diet, alcohol and hygiene.

"When all is said and done, death and disease are inevitable. As we eradicate one scourge, another will take its place. Health care is only one element in the quality-of-life equation; the other elements, which depend on national will and individual responsibility, are equally important, if not more so."

So where does this leave us? In my opinion, the social changes that have occurred in the last decade, the phenomenal human interest in our health and well-being, the deep concerns over our self-enhancement and our environment provide a climate appropriate for new directions in health philanthropy.

### 7% growth rate

With four billion dollars in annual expenditures and growing at the rate of 7% per year, health philanthropy could potentially have a far greater impact on health care in America than it does at present. There are many signs though today that health philanthropy is tradition-bound.

About $1 billion a year of health philanthropy is spent on personal health care services. At a time when most Americans have some form of health insurance and real out-of-pocket health expenditures are actually declining, it is inappropriate, in my opinion, for such a substantial share of health philanthropy to be spent in this manner.

Nearly another quarter of all health philanthropy—about $900 million annually—go to health agencies that, as Dr. Thomas notes, tend to take a disease-by-disease approach to the human condition. More often than not, their funds are used for the consumption of health services rather than being invested in basic research into the underlying causes of disease. And as you know, in some health agencies, the fund-raising costs are excessively high. The question must be asked: who really benefits from these agencies, and are the benefits to society greater than their costs?

Finally, 20% of all health philanthropy—three fourths of a billion dollars annually—is spent on hospital construction. It would appear few donors realize that nationwide we have an excess of some 100,000 hospital beds. There are very few places in the nation other than some rural and intercity areas where there is a shortage of beds. Furthermore, philanthropy is less needed today because hospital construction, modernization and replacement costs are borne increasingly by federal and other third-party depreciation reimbursements. In addition, tax exempt bonds have become a major source of hospital construction financing. These bonds are exempt from federal (and sometimes state and local) taxes, and they enable a hospital to borrow construction funds at a substantial discount, with a resulting significant savings in construction costs.

In short, too much of health philanthropy outlays today flow toward consumption of services rather than toward investment in the health care system of tomorrow. *Too much* goes for purposes that are now being heavily supported by the federal government and other third-party payers. *Too little* goes for innovative projects.

*continued on page 28*

# Death: The inevitable winner

By Richard Crabbe

There is an old fable that tells how the young Indian brave, True Vision, trapped death.

He had reached the age when he was ready to seek a wife and move from his mother's house. But True Vision's mother became ill, and he chose to stay at her side. In the course of time, her pain became so intense that she began the Death Chant to hasten Death's arrival.

True Vision became distressed, and left to seek Death himself. Armed, he went into the forest, where he found and pursued Death. But Death proved elusive (so he thought) and climbed a tree, where the cunning True Vision trapped him.

Seemingly victorious, True Vision ran back to his mother's house, where he found her no longer chanting, though still in pain. Still joyful, True Vision went into the forest to hunt animals for food. He shot a deer straight through the heart, but it was unaffected and ran away. The same happened when he shot a second deer. Returning to the village, he found this had happened to the other hunters. It soon came to pass that seed failed to die in the ground and grow into new corn. No one died, but many didn't care to live.

Finally, the village elders counseled True Vision that it was evil to suffer so, and that he should release Death from his trap. True Vision complied, then slowly returned to his mother's house, where he sat as she sang the Death Chant.

Death, as the Indian brave in the fable discovered, is the inevitable winner. True Vision found that the "miracle" of trapping and eliminating Death had pronounced disadvantages. Finally, he learned to accept the role Death plays in the scheme of things.

In a sense, many physicians and

prospective physicians are like True Vision. Doctors try to prolong life and even when the death of a patient is inevitable. they may often go to great lengths to avoid disclosing the news to the patient.

A mid-60's paper by Barney Glaser in the *Journal of Health and Human Behavior* states, in fact, that (depending on the study) "69 to 90 percent of doctors favor not telling their patients about terminal illness."

The reasons for this, Glaser explains, are varied: physicians may not feel they are well-enough acquainted with a patient to judge the patient's ability to withstand the shock of disclosure; some do not want the patient to "lean" on them for emotional support; others may simply withhold disclosure in order to maintain peace on a ward by preventing a "scene."

At the Medical College of Georgia, nearly seven years ago, two teaching physicians, aware of this problem, decided to do something that would give the medical student a preview of what it might be like to deal with terminal patients.

Drs. Claude Wright and Russell Moores developed an elective program that puts the junior or senior medical student in the position of having to tell a "patient" that he's going to die.

Dr. Wright, a hematologist, decided that students on rotation in his area might come in contact with a greater percentage of terminal cases than in other areas, so many of the fictitious patients are leukemic.

Actually, Dr. Wright points out, the elective isn't intended to teach a student how to "break the bad news" to a patient; rather, it's designed more to let them learn how to cope with their own feelings about death.

Dr. Moores, a member of MCG's department of humanities, agrees with this approach.

"They (students) have to collect their own thoughts, get at their own attitudes toward death and dying in order to do this with a patient, or with a simulated patient, in this instance. This is what we're trying to do—make them come to grips with this themselves, so they can better be able to help somebody who is in danger of death."

The elective is conducted in a series of sessions over a two-week period. The students first sit in a seminar which outlines the purpose and goals of the course. Wright, Moores and Rev. Daniel Munn—a colleague of Moores on the humanities faculty—direct these sessions.

Students are given material on the problems encountered by working physicians, including the Glaser study and excerpts from a previous MCG course on death, incorporating research material by Dr. Elizabeth Kübler-Ross.

The actual meeting between "physician" and patient" takes place not in the relative privacy of an office or examining room, but under the hot quartz lights of a television studio.

The "patient" is an actor. The student is given a medical history and diagnosis based on lab test results that indicate a potentially terminal leukemia. Based on this information, he must tell the "patient" that death is imminent. The interaction between "doctor" and "patient" is often suprising.

"(It) calls into use everything they have done in their four years of medical school," says Dr. Moores. "They have to use all their science knowledge, all the knowledge they have of taking care of patients in order to sit down with this person and discuss with them the illness they have."

The encounters, lasting from 10 to 15 minutes, are recorded on videotape for review at a later session. There is no rehearsal—student and actor are unacquainted—and the spontaneity of the meetings is often surprising . . . and realistic.

"It (the session) is tailored individually because when the student starts in with the patient, from the time they first open their mouths, the interactions from that point on are not programmed. That 'patient' is going to react one way and the student to that, and the whole purpose is to see what this interaction was. Then (we) analyze it for them and point out to them things that facilitate what they are trying to do, and certain behaviors that impede what they are trying to do."

The final sessions are given to critique and involve students, faculty and the actors. Everyone is free—in fact, encouraged—to comment on the taped encounters, adds Moores.

The turnout for the course, which is offered on a 9 to 10 week rotation, has grown over the years, but the sessions work best when the numbers are limited, generally 8 to 10 students, sometimes fewer.

Dr. Wright estimates that perhaps 90 or 100 students have participated in the death and dying sessions, and while he feels the course can do nothing but benefit the medical student, he can't recite figures to prove or disprove his contention. No former student, he says, has ever come back and said whether the course made "breaking the news" easier. And it's quite likely that none ever will. Practice and role-play all you will, he contends, but telling a patient that death is imminent is still the physician's most despised task.

# Sesquicentennial Endowment Fund Summary

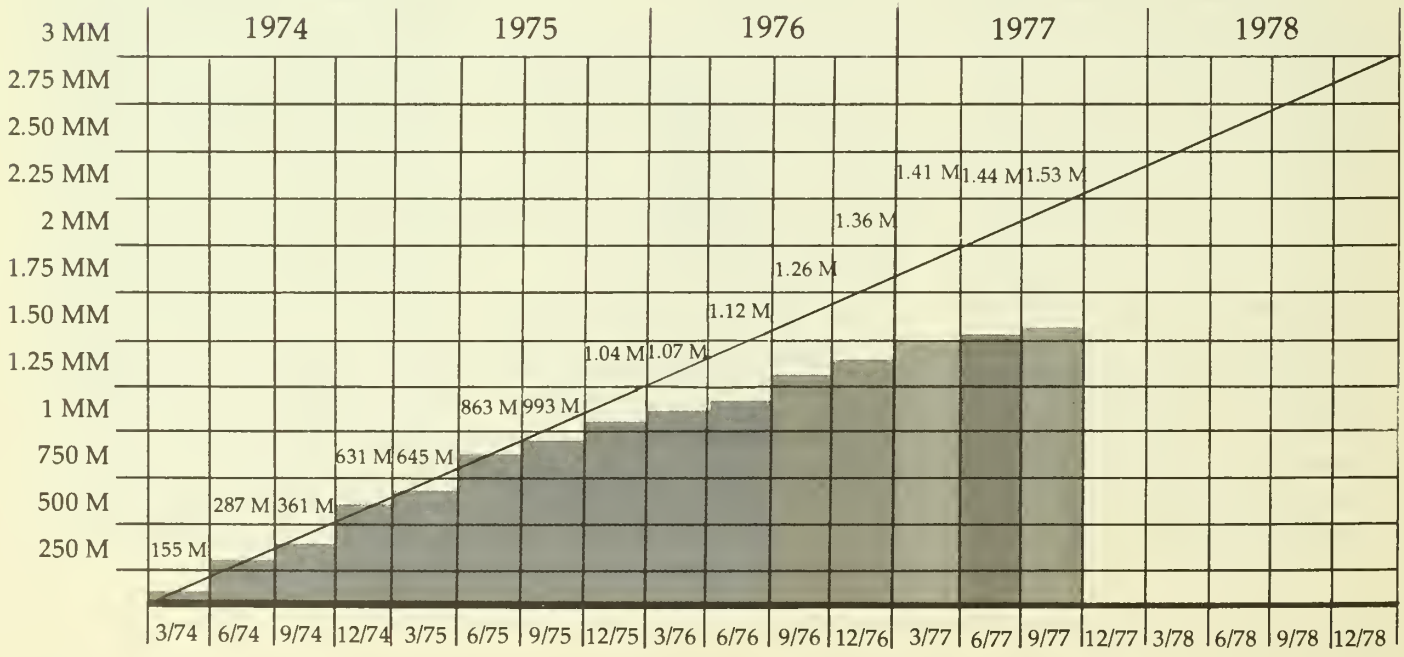
**SUMMARY (Totals by constituency all regions)**

**AUGUST 1977**

| | Year to Date | | | | Campaign to Date | | | |
|---|---|---|---|---|---|---|---|---|
| | No. | Amount Pledged | No. | Amount Paid | No. | Amount Pledged | No. | Amount Paid |
| *F & S | 2 | 10,532.88 | 676 | 21,967.60 | 972 | 360,558.61 | 3345 | 200,100.93 |
| Individuals | 29 | 70,881.24 | 45 | 73,265.24 | 143 | 263,431.93 | 146 | 237,715.93 |
| Corporations | 11 | 3,635.00 | 34 | 34,701.68 | 92 | 255,990.00 | 119 | 156,019.40 |
| Foundations | 6 | 19,725.00 | 8 | 20,975.00 | 32 | 160,277.88 | 34 | 130,027.88 |
| Alumni | 116 | 62,987.90 | 244 | 33,007.93 | 825 | 484,565.47 | 1065 | 286,254.22 |
| Parents | — | — | — | — | — | — | — | — |
| TOTALS | 164 | 167,762.02 | 1007 | 183,917.45 | 2064 | 1,524,823.89 | 4709 | 1,010,118.36 |

*All faculty and staff are recorded in the Augusta area

*Graph shows quarterly progress of the Sesquicentennial Endowment Fund pledges since the kickoff of the campaign in 1974.*



# Report at a Glance: Through August 1977

**SUMMARY (Totals by region all constituencies)**

**AUGUST 1977**

| Region | Year to Date | | | | Campaign to Date | | | |
|---|---|---|---|---|---|---|---|---|
| | No. | Amount Pledged | No. | Amount Paid | No. | Amount Pledged | No. | Amount Paid |
| 1 Albany | 2 | 1,950.00 | 13 | 2,000.00 | 57 | 41,920.20 | 73 | 27,573.62 |
| 2 Athens | 3 | 225.00 | 6 | 450.00 | 30 | 10,410.00 | 39 | 7,760.00 |
| 3 Atlanta | 47 | 42,907.90 | 58 | 15,214.50 | 131 | 88,178.10 | 156 | 44,889.20 |
| 4 Augusta | 28 | 49,131.62 | 761 | 84,783.02 | 1216 | 838,060.70 | 3666 | 485,440.09 |
| 5 Brunswick | 1 | (6,450.00) | 1 | 250.00 | 15 | 6,570.00 | 16 | 5,570.00 |
| 6 Columbus | 6 | 15,862.50 | 30 | 25,046.50 | 40 | 115,052.50 | 85 | 78,094.83 |
| 7 Gainesville | 4 | 300.00 | 9 | 1,240.00 | 15 | 46,155.00 | 26 | 40,370.00 |
| 8 Macon | 18 | 2,185.00 | 34 | 3,085.00 | 112 | 40,626.04 | 116 | 30,261.04 |
| 9 Rome | 1 | 1,000.00 | 14 | 5,127.00 | 26 | 18,937.00 | 48 | 44,237.00 |
| 10 Savannah | 3 | 675.00 | 8 | 1,575.00 | 53 | 26,610.00 | 62 | 22,410.02 |
| 11 Valdosta | 1 | 1,000.00 | 3 | 1,253.58 | 12 | 7,680.76 | 16 | 7,042.18 |
| 12 Waycross | 1 | 26,875.00 | 2 | 29,175.00 | 26 | 38,309.79 | 40 | 36,609.79 |
| 13 Dublin | 2 | 125.00 | 4 | 300.00 | 8 | 1,750.00 | 12 | 1,375.00 |
| 14 Thomasville | 1 | 100.00 | 1 | 100.00 | 11 | 1,875.00 | 12 | 2,000.00 |
| 15 Statesboro | 2 | 25,030.00 | 5 | 2,165.10 | 22 | 150,466.05 | 26 | 124,529.94 |
| 16 Griffin | 1 | 250.00 | 1 | 250.00 | 5 | 540.00 | 5 | 540.00 |
| 17 Tifton | 5 | 1,660.00 | 5 | 1,660.00 | 12 | 2,860.00 | 12 | 2,860.00 |
| 18 Carrollton | 1 | 50.00 | 1 | 50.00 | 3 | 175.00 | 3 | 175.00 |
| Out-of-State | 37 | 4,885.00 | 51 | 10,192.75 | 270 | 88,647.75 | 296 | 78,380.65 |
| TOTAL | 164 | 167,762.02 | 1007 | 183,917.45 | 2064 | 1,524,823.89 | 4709 | 1,010,118.36 |

# Rinker Urologic Society Honors Dr. Greenblatt

*EDITOR'S NOTE: Earlier this year Dr. Robert B. Greenblatt was honored by the Rinker Urologic Society. The society elected him to honorary membership. Following are excerpts from the after dinner addresses made at the society's annual banquet held in Augusta.*

Dr. Henderson: We are going to press Dr. Rinker into service one more time to present Dr. Greenblatt.

Dr. Rinker: As I have said before, you will learn things in this part of the program that you won't learn anywhere else! In the future this particular part of the program will change a little. In the past, all of our guest speakers have been friends and contemporaries of mine. I hope I am not running out of friends, but I am fast running out of able contemporaries. Fortunately, I have one left, Dr. Robert Greenblatt, who we are thrice honoring tonight. First, we consider it an honor to be asked to be our guest speaker, secondly, he is the only speaker we have had that was not a urologist. He deserves this recognition from us because his contributions have been of significant importance to the field of urology. Thirdly, we have defied

*Dr. Robert Greenblatt, center, earlier this year received honorary membership to the Rinker Urologic Society. With Dr. Greenblatt are Dr. William D. Henderson, left, Alexandria, La., president of the society and Dr. J. Robert Rinker, for whom the society was named.*

the scriptural injunction that a prophet is without honor in his home community. Bob, we recognize your accomplishments as a teacher, physician, researcher and author of ten books, eight on various aspects of endocrinology and one of the Bible. He was a pioneer and one of the founders of the specialty of endocrinology and is in demand internationally as a speaker. If you go from the waiting room to his private office you will see the walls covered with plaques, certificates of honor, etc. from all over the world. He won't ever need to paper the wall! I understand that the one of which he is most proud was given to him by the President of France, "Chevalier of the National Order of the Legion of Honor". Now a chevalier is a horseman, and a horseman is one of the things he is not, but with a little research into heraldry, I found that in this case he is a knight of the highest honor.

I have known him longer than any other person in Augusta. When I came for an interview, Dr. Kelly talked to me for about a half an hour and then turned me over to Dr. Greenblatt. Perhaps this had a favorable connection, I don't know. They asked me to have dinner with them that evening and I joined him, Dr. Kelly and a drug salesman at the Partridge Inn. The drug salesman picked up the tab. This shows how precocious he was, because it took fifteen years for the rest of us to catch on to the bounty of a drug company. Well, they needed some help. The budget of the medical school was $312,000. in 1943. You had to be frugal to survive. For your information, the last approved operating budget was $75,000,000.

Dr. Greenblatt came to us from the French speaking part of Canada as a resident in gynecology. I want to quote from Johann Strauss' "Die Fliedermaus". The setting is a grand ball in the Czar's palace. The scene is at the edge of the curtains surrounding the ball room where three young ladies are standing, apparently hoping some partners will come and ask them to dance. They are approached by three young men. The first starts to say something and is curtly interrupted by the second who says, "You speak to a lady in French"! The third breaks the impasse by saying, "It's alright to communicate with a lady in any language she understands". I understand that Bob is fluent in both languages. Well, maybe he does have some insight into the female world that the rest of us don't have. You know the basic story about "The way of a man with a maid", the salesman and the school teacher. Well, in his book he turns this around, "The way of a maid with a man", and if I interpret it correctly, the maid holds all the trumps.

Shortly before I came for my interview he had just arrived on the national scene, not as a gynecologist but as a research venereologist. He had received the highest award at the A.M.A. meeting for his work on granuloma inguinale. All the research that had been done was from contaminated ulcers and the role of the Donovan bodies had never been clarified. Mr. Bob spied one of these abscesses before it had ruptured and aspirated it. This was the first time anyone had had a pure culture of Donovan bodies to study. This led to his being invited to write a manual on venereal disease for the U. S. Public Health Service.

Now, I was in the venereal disease business, too, and I had wondered how this would work out when I joined the faculty, but when I came three months later he had gone to the war and by the time he got back, penicillin had come in and the general practitioners had put us both out of the venereal business, so some things settle themselves. As I used to tell my children, you don't have to make a decision on everything on the basis of today.

We worked together on many things. This morning, he showed some of the early reported cases of sex change in which I did the surgery for him. We only operated on those that had an organic indication so we didn't get the acclaim that they did with Christine Jorgensen, but we got all we wanted at the time.

I have given you some early background and you all know of his accomplishments since.

This morning he spoke on "The Hormonal Evidence of the Male Climacteric", and I wish that all of you could have heard him. Edith

Bunker says, "When a woman gets it it's the men-o-pause, so when a man gets it it must be the woman-pause.". This just shows that there is more than one route to a conclusion.

When we went over to see the news people about announcing this meeting, I said, "I want to tell you something about our guest speaker, Dr. Greenblatt". They said, "That's not necessary. We keep that type set up all the time". There was an article in Parade, the supplement of a recent Sunday's paper telling about his part in developing the "pill" and the better "pill" to come.

I, personally, want to thank you for a long and friendly relationship and express for the Society our appreciation for your participation in our program.

Dr. Greenblatt:—

This Society is a testimonial to Dr. Rinker, but thank you, Bob. When my wife asked me what I was going to talk on tonight, I said, "Testimonials, Testicles and Bob Rinker". Because your very presence here tonight is a testimony to a great man and a great friend of mine and yours. My wife said, "If I know you, Bob, you've come to bury Ceasar, not to praise him". And I'm not going to let my wife get away with a quotation from Shakespeare. I had to think of one fast and I remembered in Julius Ceasar when Shakespeare said of Brutus, "Let me have men who are fat about me. Young Cassius has a lean and hungry look. Such men are dangerous". Let me say this, "Don't worry, Bob, it is far easier for a thin man to pass through a needle than for a fat man to reach the gates of heaven". I've known Bob for almost 35 years now. I can say that here's a man with a tremendous wit, it's a dry wit and you catch that humor as you talk with him. He's a philosopher, a homespun philosopher and he often reminds me of the great Will Rogers. He has many attributes but one of the great virtues is his humility.

We've had a cook for 31 or 32 years and she often sings for us, "I Have the Whole World in My Hands". I want you to know that here we have Bob Rinker who has had the world veritably by the gonads—and I want to tell you the importance of gonads in history. The first savage who defeated his adversary in battle—removed the gonads of his brave adversary and ate them because he believed courage and verility came from the gonads. He was the first endocrinologist. In Deuteronomy, we find a passage, "He who is wounded in the stones shall not enter into the congregation of the Lord". And you know that sanction has been followed throughout the centuries and even the Catholic church would not allow a priest who was a eunuch to be ordained. Even 2,000 years ago Matthew tells us that Jesus said that there are eunuchs so born from their mother's womb. An example of congenital eunuchoidism. The biblical passage goes on to relate that some eunuchs were so made by man. Eunuchs were castrated so as to become harem guards and chamberlains and others became eunuchs so that they might enter the kingdom of God. Origen, the great theologian of the 3rd century had himself castrated so that he could teach women in the ways of the church as were the choir boys in the Sistine Chapel that were castrated in their youth in order to maintain their beautiful voices into adulthood. They were known as the castrati. This doesn't jell with the concept that he who is crushed in his stones or had his testes removed could remain in the sanctuary of the Lord because even the Pope before he could be ordained or elected to popeship had to prove himself. He was placed on a throne with a hole in the seat and as he was carried on the shoulders of the cardinals who had to verify, de vistu et tacto, that the "elect" indeed had testicles and ascertain that the pope had every right to enter the sanctuary of the Lord as they pronounced the verdict. Bob, I want to say that all of us have been richer for knowing you and I'm about the only one who is poorer because I'm going to give you a book of mine that cost me $8.95. (The book is "Search the Scriptures" by Dr. Greenblatt).

Dr. Henderson:—

Dr. Greenblatt, we have made you an honorary member of the Rinker Urologic Society and I present this certificate to you. Perhaps you can find a spot on that wall to hang it.

# Research Responsibility of University Faculty

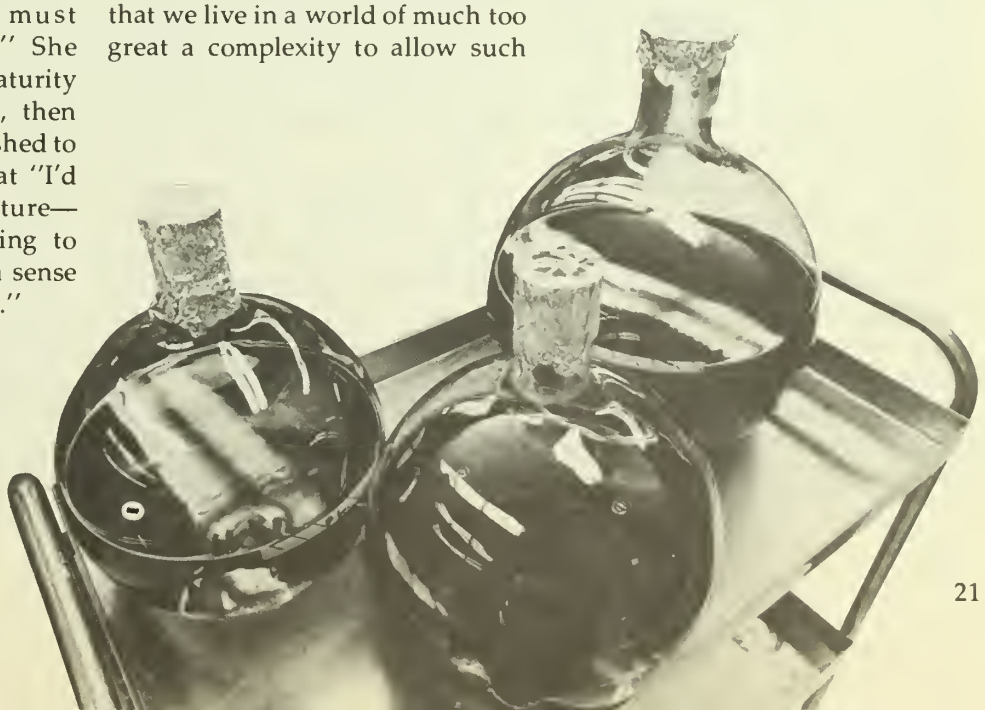
**By Dr. John W. Hooper**
**Vice-Chancellor—University System of Georgia**

The typical discussion of academic research today tends to center on concepts such as "hard" and "soft" money; "sponsored" and "general" research; "indirect cost recoveries"; "released time"; "publish or perish"; "be sponsored or perish" and similar terms. While all of these concepts are important, and are completely fair game for any discussion period which may follow this talk today, I would like to direct my attention to an entirely different aspect of research; namely that implied by the motto of Sigma Xi—"Companions in Zealous Research."

An enthusiastic devotion to a diligent, protracted investigation or studious inquiry remains one of the most rewarding experiences available to man. Margaret Mead said it most succinctly in recent remarks to a National Council of Churches Conference when she stated that Americans must become more "immature." She said, "the next thing after maturity is senescence, then senility, then death." We are well admonished to heed her when she says that "I'd rather be a little bit immature—openminded, exploring, living to the last day on earth with a sense of excitement and discovery."

The human intellect would appear to be a unique characteristic distinguishing humankind from all other animate and inanimate components of the known universe. The joys accessible through thought processes never cease to amaze me. It has always seemed appropriate in my own experience through research to find that some of the greatest thrills have come not through the development of the final proof or the concluded experiment but rather at the darkest hour when all previous attempts have failed, all avenues of investigation seem to have been covered, and suddenly you have insight as to something else to try. It really isn't too important that the "something" probably fails also—you did your best, you had a good run for your money and you can proceed secure in the knowledge that nature never "sandbags" you and that sooner or later a new idea will come to spur you on again.

But you might legitimately say that we live in a world of much too great a complexity to allow such self-indulgence on the part of the individual researcher. What about the concept of mission-orientated research and the need for the application of one's energies to problems relevant in contemporary society? With energy crises, environmental pollution, economic instabilities and socio-political problems can we afford to focus our attention on basic research in the physical, chemical, and biological sciences, political and social sciences, and the humanities? Obviously, as usual, the answer is one of proper balance—the key is the placement of the fulcrum at the proper point between pure and applied research. Parenthetically, it is interesting to note that in an extensive study of the relative contributions of basic and directed research to major advances, published in *Science*, several years ago, that the two avenues were almost equally productive. The trail that leads



from the work of Linus Pauling to that of Watson and Crick by way of the X-ray crystallographers and then to contemporary geneticists and political scientists, philosophers, and citizens who are wrestling with the problems of recombinant DNA is necessarily a tenuous one. And yet all are involved in pure or applied research.

I have approached my subject in this somewhat obtuse way in order to make the implicit point that the essential ingredient required for effective research is leadership. This is true whether we work alone or as part of a group. As established researchers you, and others like you, represent the leadership potential of the University System. What kind of leader are you? What kind of leader can you become? What kind of leader should you become?

While I know it is presumptuous of me to do so, I would like to make a few observations with respect to that last question. First of all, you are faced with a difficult environment in which to meet leadership responsibilities. Higher education has become one of the most regulated aspects of American life. Guidelines, policies, procedures, and constraints appear, disappear, conflict and overlap with ever increasing frequency. The constituencies to be served are exceeded only by the pressure groups which coalesce about many of the features which differentiate our society. No wonder President Warren C. Bennis recently noted in an article in *Technology Review* that "The university is, in a sense, an anvil on which a fragmented society hammers."

But as President Bennis and many others have noted there is another more important psychological barrier than that of general societal discomfort facing the research leader. That is the concept of limits. We face a serious problem as a consequence of energy and related shortages that manifests itself as an attitude that mankind must retreat into a shell of conservatism of thought. I have no quarrel with conservation and sacrifice, nor am I an advocate of the position that growth and bigness are necessarily good. But neither am I willing to concede that "small is good" or that a moratorium on creativity and entrepreneurship are in order. It has been noted that a grain of sand is smaller than the glass which it comprises. Why should mankind be willing to view the beauty of sand and experience the privations incurred by a loss of glass? Enlightened research leadership, sensitive to all aspects of a problem set, can prevent the necessity of having to answer such questions.

How then does one provide enlightened research leadership? In my opinion, the answer is both simplistic and profound. Engage in those things which your experience and your training and your intelligence tell you are most important. Never pursue a program of research that demands less than your best intellectual effort. Never settle for personal results or those from colleagues which cannot stand up under the most severe objective scrutiny. Risk your time on potentially high yield problems in areas related to your own skills. By so doing you will indeed become a "Companion in Zealous Research."

The translation of these basic tenets into a successful research program is not easy. One of the most difficult aspects comes at the first step when it becomes necessary to define the problem. I can cite numerous examples of research activities of long standing that have never addressed themselves to specific, well defined, problems of the basic importance warranted by the skills and training of the principal investigators. The phrases "energy problem", "environmental pollution", and "inflation" are not descriptive of specific problems conducive to solution through the application of research techniques. Instead we must peel several layers off the pearl (or onion) and determine the true nature of the question. We might, for example, find it necessary before undertaking a study of inflation to define our present situation as one in which increasing prices are occurring in the presence of excess production capacity. The study of economic or monetary systems under this condition of *stagflation* will necessarily be quite different from related studies which might be conducted under conditions of limited capacity. Those of you who have had the opportunity to study some of the work of Dr. Jay Forrestor as described in his books and papers on industrial and urban dynamics are familiar with the fact that in complex systems human intuition may well suggest programs and practices which produce results of a nature exactly opposite that which is expected. I bring this example up only to emphasize that extreme caution is required in the definition of specific research objectives.

It is a paradox that research creativity seems to be stifled by funding success. A typical pattern extant within the University System (as well as elsewhere throughout the country) is that of a research group which at some point in the past received substantial research support permitting the development of a highly competent group of research specialists. Following the completion of the initial grant objectives and funding period the group leader

found it necessary to secure additional funding to occupy the time and talents of his group. Unfortunately as this cycle continues the group becomes the object being served rather than the research objectives. While funding continues to be readily available as a consequence of the research paper productivity and professional meeting activities of members of the group the work may no longer represent those things which experience and training and intelligence dictate are most important. The work has become "safe" in contrast to "creative." Unfortunately this can happen to the individual faculty member working alone as quickly as it can happen to a large group or research team. Only leadership can minimize such problems.

Dr. Stark Draper of the MIT Instrumentation Laboratory was the most successful research and development manager that I ever had the opportunity to know. The Instrumentation Laboratory which operated until the severe student unrest period of the late 1960's was the developer of the guidance and control systems and computers for the Apollo missions and earlier for much of the avionics development work for the military. Many of the leading scientists and engineers of the country have at one point in their careers worked with the Instrumentation Laboratory. Dr. Draper's management concept was to maintain a small cadre of research leaders and structure the remainder of the research and development teams from faculty, postdoctoral fellows, graduate students, and young scientists and engineers who were hired by the laboratory for a known short interval of time. At the completion of any specific project, the team was totally dissolved and others reformed to address new projects. No group continuity insured that projects were not developed just to keep the group occupied with more work of the same type. It's high pressure research and development—but it works.

The academic research of the University System can also be kept alive and well if we are willing to face up to these and related management and leadership factors. We are blessed, as is any academic community, with excellent research colleagues among our fellow faculty members, and perhaps even more importantly by a constant supply of student associates with skills ranging from those of the undergraduate to the postdoctoral fellow. We must never lose sight of the fact that the education and training of these students is the central mission with which we are faced. I believe that it is fair to say that no research activities should be undertaken in an academic setting unless that research at least potentially involves students. They can bring much of that needed "immaturity" into your life to which Magaret Mead referred.

I am at this point going to do what is undoubtedly an imprudent thing: and that is attempt to define the research role of a faculty member within the University System. All of the usual qualifiers apply to the effect that this is a personal opinion only. However, I must acknowledge that I will work as diligently as possible to make the model a reality.

Each of us, as a professional employee, owes a full time professional contribution to our institution. This contribution may consist of varied components of teaching, research, and service depending upon the overall mission of our institution, our own specific competencies, and specific opportunities and responsibilities at a particular time. We are entitled to fair and equitable compensation consistent with our productivity and professional performance. It is essential that our personal motivation be directed toward the intellectual and skills development of our students, our colleagues, and ourselves. A lessening of this effort with time or tenure will not occur as long as we continue to grow. The definition of our research efforts must be made based on what we know to be most important—not on what is in favor with a specific funding agency at a particular time. Our results must be objective and arrived at in a truly hard-nosed fashion. We must expect and accept nothing less from our students.

Perhaps Professor Loren Eisley said it best in one of his essays which I read years ago. You have perhaps heard me cite this example previously as it has become an important aspect of my personal philosophy. Dr. Eisley, a noted anthropologist and author, observed that from his experience all anthropologists involved in the exciting search for the origins of man seem to fall into one of two groups which he characterized as "little bone hunters" and "big bone hunters." A little bone hunter spends a lifetime of ill defined search while a big bone hunter devotes his total effort to the pursuit of that which is a fundamental importance to his field. It is possible that a little bone hunter will find a big bone—but only by accident. It is also possible that a big bone hunter may spend an entire lifetime without success. Still the implications for research, for society, and most importantly for you and for me are obvious. I cannot help but conclude but by wishing for each of us a "big bone hunter" philosophy and practice of research.

# Mike and Jenny. . .not just playing doctors

**By Linda Wilson**

It's 7 a.m. when Michael Evans and Jenny Hawkins arrive at the Screven County Hospital. They carry all the "trappings" of the physician—white lab coat . . . stethoscope bulging from the pocket and . . . the inevitable "black bag".

The day begins in the hospital laboratory where Michael and Jenny assist with the day's "blood work." The lab work is handled quickly and efficiently and then it's time to make rounds. There are patient histories to be taken, physicals to be given, hearts to be listened to . . . a multitude of things to do.

Before 9 a.m. you will probably find Jenny and Michael scrubbing for surgery. If Jenny's running a little late, it's probably because she is still searching for the only "small" surgical gown in the hospital.

The surgery goes well and the patient is sent to the recovery room. It has been a long morning, but in many ways the work day has just begun. The rest of the day may call for seeing patients at the Family Practice Clinic, the local health department or the doctor's office. In addition, there are emergency cases and administrative duties.

To most people, this description may sound like a typical day in the life of any physician. And, in reality, there is only one thing that's atypical about it—Michael and Jenny are not doctors—at least, not yet. In fact, they are first year medical students at the Medical College of Georgia, and just two of the twenty-five MCG students who received local health care experience this past summer through MECO—Medical Education Community Orientation.

MECO, a national project of the Student American Medical Association, is designed to attract first and second year medical students to primary health care medicine and to geographical areas now underserved by physicians.

Jenny and Michael spent ten weeks this summer working with the staff at the 52-bed Screven County Hospital in Sylvania, Ga. Under the watchful eye of Dr. William Kent and Dr. Kathrine Hawkins, they received valuable clinical experience as well as in-depth exposure to rural health care.

Dr. Kent and the staff at Screven give full support to the MECO program. "This is the fourth group we've had here and they've been excellent," says Dr. Kent. "They do everything from seeing patients and attending staff meetings to taking emergency calls on weekends. We work them hard. They are treated like doctors not students. We want them to see what rural practice is all about."

Dr. Kent points that the program

has been so successful that three of the past participants have returned to Sylvania during their vacations and free time to work at the hospital.

How do Jenny and Michael feel about their MECO experience? If you could see them at work, you wouldn't have to ask. But if you do ask, you will receive an excited and enthusiastic response.

Michael will probably tell you about being first assistant during an abdominal hysterectomy, or learning to write prescriptions, or actually doing a spinal tap. At the same time, Jenny may be talking about suturing a facial lesion, giving a complete physical exam, or watching a baby being born.

Both students have nothing but praise for their MECO experiences in Sylvania. "It's making us diagnosticians," says Michael. "We are learning to meet and talk with the patients and to evaluate and present cases to the physician. We are receiving practical experience. We are closely supervised and observed, but we are not just playing doctor."

Jenny points out that getting to know the physicians is one of the most enjoyable aspects of the program. Her contact with Dr. Kathrine Hawkins is answering many of her questions concerning the role and life style of the female physician. "I'd never even worked in a hospital before," says Jenny, a former speech pathologist. Now I'm 100% more excited about medicine."

One question Jenny and Michael heard frequently is how do you feel about living and working in a rural setting? The answer to this question was easy for Michael, a hometown boy. "I've lived here all my life. I love it," he says.

Jenny, a native of Roberta, Ga., admits that she had totally discounted working in a small town before her experiences with Sylvania's medical community.

Both students were impressed with the relaxed atmosphere of the rural hospital. "We really treat the total patient here," says Jenny. In many cases the doctor knows the whole family. The patients love their doctors and they rarely gripe or fail to follow orders."

The benefits to the student in the MECO project are numerous indeed. He bdnefits by the education he received his formal studies become relevant, his choice of specialty and practice location more informed and his comprehension of the physicians life style more accurate. But there are benefits for the physicians and the community also. The physicians benefit from the stimulation of student teaching and student questioning and from the continuing education credit they are eligible to receive. In addition, the community gains exposure to a young professional who may return to the community to practice.

# The answer was obvious

**By J. Harold Harrison, M.D.**
**Class of '48**

Coming from the farm in Kite, Georgia, I naturally went to the University of Georgia and applied to only one medical school. I attended the Medical College of Georgia during the war period, at which time, the clinical years left much to be desired. Upon completion of medical school, in spite of my being among the top of the class, I was embarrassed by individuals in some of the institutions where I was interviewed for an internship. It was later apparent that very little help was given to myself or anyone else by the faculty in obtaining proper training positions. My surgical training plus research and clinical opportunities in developing vascular surgery were at Grady Hospital and Emory University.

Why should I, therefore, under the circumstances want to help the Medical College of Georgia? Reflecting on the matter after a few years, the answer was obvious, and I was the perfect example. This is our state school available to all and capable of being anything that the Alumni with our support and influence could make it.

How can this be done?

In recent years, the governmental change of emphasis from research support to health care delivery has reduced the research money previously available in abundance to such proportions that medical schools have been left with the difficult task of balancing their budgets. Inflation, fixed endowments, stock market losses, etc., have placed private institutions in financial difficulties. State supported institutions, though hard hit, have fared better and are left in the good news-bad news position. Although they are limited by law as to how much money they can pay their faculty, the MCG Foundation can add sufficient base pay support to not only keep the good ones, but also to attract those of excellence from the other institutions. With proper Foundation support, there is no reason that our state school should not have the best faculty available anywhere.

Scholarship loans exist where one dollar is matched with nine from the Federal Government. When these loans are re-paid, the matching money goes back to the pool to support further Federal matching grants. Simple arithmetic tells you that, ultimately, we should be able to build up a fund which, when combined with the comparative low tuition fee at our state school, should create a situation wherein no deserving student would be kept from receiving a quality medical education for lack of financial support.

The money pinch has also increased the competition for research grants such that many bright, energetic young individuals who have great potential but no reputation are left out. Adequate support to provide seed money to initiate their research projects can lead to larger grants

and is quite often the launching pad for the development of our leaders for the future. This may well be the most valuable money spent, as it provides an incentive to keep deserving individuals in research and teaching.

State schools are also limited in miscellaneous expenditures such as expenses for recruiting prospective faculty, their moving expenses, etc. There are multiple other small items where a few well-placed dollars go a long way. Add up all these factors and it is apparent that there is no better bargain available than supporting medical education and delivery of quality health care in our area for the future.

How can this be accomplished?

It all starts with financial support. In spite of what excuses we may give, there are very few who are not able to give more than we have ever considered, and the response from Alumni to the current endowment fund drive has so far been, to me, rather embarrassing. Being awarded an M.D. Degree regardless of what we think of the institution from which it has been rendered, has allowed most of us to enjoy much of life's blessings. We really owe, if nothing but from a pure financial consideration, something to support the cause that made this possible. Hippocrates, whose sacred oath we took upon receiving our degrees, wisely and openly swore *"... to reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required..."*

Once we have given our money, which automatically increases our degree of concern and interest, other forms of support such as public relations, influence on legislators, etc., is a natural. When the Foundation approaches the outside world about supporting funds, the first question always raised is what have your Alumni done. If those you have educated don't feel sufficiently responsible to support your cause, then why should we? Doctors, in our usual outspoken support of the concept of free enterprise, should consider this a unique opportunity to participate.

What is our return on such an investment?

Distribution of the Foundation funds is controlled by the Board of Trustees. This is made up of a balance of faculty and business leaders, but is basically controlled by Alumni members. As the support increases, you can see the potential influence. I have observed during the past fifteen years of involvement with the Alumni organization a tremendous change in the relationship between the school and its Alumni. Increased Alumni involvement has already helped the school and led to significant improvements in its educational programs and delivery of health care. We have only scratched the surface!

When someone asks me why I support the Foundation, it really boils down to a basic principle of providing what input I can to develop a medical school where a gifted individual from the state knowing no better or having no choice from a financial standpoint of attending the state medical school can look back after being out of school for 20 to 30 years and have no regret or question of the quality of the medical education that he received—one that if he had a son or daughter that is equally gifted with the option of choosing any school in the country would consider it a privilege to stay home for his medical education.

I have faith that when those in a leadership capacity can ultimately get those basic principles across to our Alumni, then the goal will be accomplished. Personal, previous grievances concerning the school will be forgotten or overshadowed by the unique opportunity to build for the future.

*continued from page 13*

### Anti-innovative

Third party payers now cover more than two-thirds of all health care spending. However, the third-party payment processes tend to be anti-innovative. There are two reasons for this. One, the claim review process employs relatively low level people. Often, these people are asked to decide only whether or not the service was ordered by a physician. They are not asked to decide whether the service was appropriate, or whether a paraprofessional could have performed the service with equal effectiveness and at a lower cost. Second, on the grounds of equity, everyone who sends in a claim must be treated in the same way. For these reasons, the third party payment system tends to be rigid and unwilling to cover new services or try out new ideas.

Thus, in spite of the enormous growth over the past quarter century of federal government health financing programs and private health insurance, there are many places in the health field that this gigantic stream of dollars doesn't reach. These are areas where philanthropy could make important contributions.

Some of these areas I have already referred to:

*1) We need to understand why Americans are preoccupied with disease in spite of the reality that we are, as a nation, abundantly healthy. Why have we lost confidence in the human form? Why are we so pessimistic about our health?*

*Related to this, we need to understand why the general public has come to expect far more out of contemporary medicine than, in reality, it can deliver. We need to examine ways in which the health-care system can be designed, or redesigned, for use when it is really needed and when it has something of genuine value to offer. We should be investing far more dollars in health services research and development than we are at present.*

*2) We need to increase our awareness of* ***environmental hazards*** *and our ability to assess genetic differences among individuals in their adaptation to the environment. We should be expanding our efforts at improving food supplies and removing hazards from the physical environment.*

*Within the past few years, we have come to appreciate that there are many major environmental factors in cancer. Such factors as smoking, synthetic compounds in our food and water, air pollution, and exposure to industrial and commercial chemicals now cause an estimated 70% to 90% of all cancer. But in respect to most substances of putative risk, our information is meager and the need for research urgent.*

*But as we move toward a better understanding of the nature and extent of different specific risks, we will encounter complex social, economic and psychological questions. We need to seek ways to remove dangerous substances from our environment while somehow reconciling the conflicting interest of various groups that have a stake in the problem.*

*3) A vast amount of our ill health is caused by the way we live and by the* ***lifestyles*** *we've adopted. There is an urgent need to raise the public's consciousness that* ***lifestyle has become the prime health hazard of this country****.*

*The biggest killer of our young people is not a disease, but accident—mainly automobile accidents. We've also seen a pattern evolve among young men, 15 to 20 years old, that the second most frequent cause of death is suicide. And for a young black man in Detroit his chances of dying from homicide are greater than from any other cause. It should not be beyond the capacity of a concerned society to reduce those needless deaths and maimings.*

**We need to understand why Americans are preoccupied with disease in spite of the reality that we are as a nation, abundantly healthy.**

*Evidence is steadily accumulating linking:*

1) *Heavy smoking with pulmonary and cardiovascular disease,*
2) *Obesity with reduced expectation of life,*
3) *Sedentary living with coronary artery disease, and*
4) *Heavy alcohol use with damage to liver and brain.*

*Yet we have not found sufficient ways to act on this evidence. If we could figure out a way to avoid cigarette smoking, we might be able to achieve a spectacular triumph in the prevention of deaths from cancer, but regrettably we haven't. The same desparing thing can be said for the preventability of death from alcohol.*

*Other destructive lifestyle habits that our society faces are:*

**Abuse of pharmaceuticals, lead-*

**Our health-care system today provides too little time to meet the important functions of caring.**

*ing to drug dependence and adverse drug reactions.*

- **Addiction to psychotropic drugs, leading to suicide, homicide, malnutrition and accidents.*
- **Social use of psychotropic drugs, leading to social withdrawal and acute anxiety attacks.*
- **High carbohydrate intake, contributing to dental caries.*
- **Fad diets, leading to malnutrition.*
- **Lack of recreation and lack of relief from work and other pressures, associated with stress-related diseases such as hypertension, coronary-artery disease and peptic ulcers, and*
- **Promiscuity and carelessness, leading to syphilis, gonorrhea and unwanted pregancies.*

### New approaches needed

***The traditional health care system has had, and can have, little success in modifying these habits. New approaches must be sought.***

*A couple of promising possibilities are health education and research. Philanthropy should support far more extensive health education programs, emphasizing individual responsibility and the relation between benefit and cost. Philanthropy also should support increased behaviorial and biological scientific research that would improve our knowledge of the role of human motivation in health needs, psychosomatic illness, family planning, aging and other sociobiological phenomena.*

*4) We need to pay more attention to* ***ethical issues*** *in health care. Our technology in many instances has outstripped our basic humanity. Faced with a scarcity of financial resources, advances in sophisticated and costly medical technology have placed us in the difficult situation of having to decide who can receive treatment. Increasingly, as Victor Fuchs pointed out, we will have to answer the question: Who shall live? In other words, do patients have the right to unlimited use of expensive medical techniques? Must doctors sustain the lives of their patients as long as technology permits regardless of the quality of the life that is prolonged?*

*Futhermore, we are faced with other complex ethical issues like abortion, death with dignity, human experimentation and psychosurgery.*

These are all areas where the government and other third party payers are likely to have a minimal influence, and yet they are crying out for much needed assistance. There are many other important areas, too, where philanthropy could make significant contributions. Among these are:

1) **Older Americans**. In our youth-oriented culture, it is frequently overlooked that ours is an aging society. Older people are the fastest growing segment of our population. In this century the percentage of people over 65 has more than doubled from only 4% in 1900 to about 10% today. If the present low birth rate continues, this percentage will continue to go up in the future.

There are now more than 20 million older Americans, and by the year 2000, their number will increase to about 20 million. Persons in retirement, or nearing it, now constitute more than 15% of our total population.

Old age in America is all too often plagued by poverty, chronic illness, a sense of uselessness, isolation and loneliness. The high rate of suicide among men over 65 speaks loudly of misery and despair. Furthermore, society's generally negative attitude about aging and the social structures that we have built encourage isolation and segregation of older people. Philanthropy should be paying far more attention to these problems than it is.

2) **Caring.** Our health-care system today provides too little time to meet the important functions of caring. Frequently, patients simply need someone to compassionately listen to their problems, to sympathize with them and to help them work out their difficulties. We need to find a better way of providing time for someone to spend with individuals who are anxious or who need reassurance that they are not coming down with something serious.

Many people visit doctors for advice about living: what should their diet by? Should they take a vacation? What about a tranquilizer for everyone's inevitable moments of agitation and despair? We should be trying to develop improved ways for handling these questions through new types of counselling services.

We also need more counsellors to work with such problems as teenage pregnancy, venereal disease, drug abuse, and alcoholism. And we need to find better ways for providing for patient follow-up. Was the treatment regimine followed? Are there any questions about what to do? These are questions for which we need trained health guidance counsellors.

3) **Planning.** We need to find better ways for enlisting hospitals, medical schools and other health facilities in a serious planning process to avoid excess capacity and needless duplication of facilities, to promote the efficient sharing of expensive equipment, and to consolidate residency-training programs in order to avoid duplication and insure the minimum size required to sustain a high-quality effort. The need for such planning is critical.

There is no earthly reason, for example, for every hospital to expend half a million dollars to purchase a new CAT scanner, a sophisticated x-ray and computer diagnostic tool. In Southern California already, there are enough CAT scanners for the entire western United States.

4) **Cost efficiency and effectiveness.** We should make greater efforts to encourage the development of well-designed, larger-scale tests to determine the effectiveness of medical technology and to evaluate new methods of patient care. At present, there is no satisfactory means for evaluating new types of laboratory tests and new technological devices in order to make sure that their benefits are worth the cost.

Similarly, expensive new procedures are being introduced every month without a satisfactory showing that they bring lasting improvements to our health. For example, thousands of people have already received coronary by-pass surgery at a cost of at least $7,000 to $10,000. Up to 4 million persons are potential candidates for this procedure, and under national health insurance they might succeed in having these operations performed at total cost to the country of $20 billion. And yet, although some comparative studies have been made, no controlled clinical trials have been performed thus far to determine reliably whether the operation has any significant effect on preserving human life.

5) **Reforming the health-care system.** HEW secretary Califano in his recent speech before the American Medical Association, said:

"We know that any long-term strategy for reform in the health system must:

(A) Provide alternatives to costly institutional care—whether in hospitals or nursing homes.

(B) Encourage the substitution of general primary care for most costly specialized care wherever that is possible without lowering quality standards.

(C) Expand and make more efficient the use of less expensive health care personnel.

(D) Stress prevention and early treatment—especially among our children—to avoid unnecessary illness, disability and death.

**Resources are limited**

For too long, all of us in health care have been using our affluence to cure problems, rather than our ingenuity and self-discipline to prevent them. We have not been willing to confront the hard fact that *resources are limited.* We must find new methods to provide quality health care to all Americans at a reasonable cost.

"Now, the cost of our indulgence is catching up with us. We can no longer buy our way out of difficulties. We *must* think our way out."

The challenge to do better is substantial. And yet my experience in Washington tells me that the federal government will be very slow in adopting new solutions. Enlightened leadership is also not likely to come from private health insurers because they lack the necessary incentives to change the status quo.

Clearly, there are major opportunities today—as there have been in the past—for philanthropy to provide the necessary and important funds for innovation and experimentation in the health field. Philanthropy, in my opinion, should not be bound to traditional ways of doing things. Rather it should be providing seed money, risk money and flexible kinds of support so vitally needed to allow us to address the new health problems that we, as a nation, face today. In so doing, philanthropy will be acting in the public's best interest, and it will—at the same time—be building ample support to justify its continued preferential tax status.

And as fund raisers in the health field, it is in your own best interests to see that precious philanthropic dollars are directed to projects and programs where they will be making the highest and best contributions to our society's advancement.

# Alumni News Events Activities Class Notes Alumni News Events Activities Class Notes

## DEATHS

Willis McCurdy, Stone Mountain, Ga., 1931
J. Joseph Bennett, Hollywood, Fla., 1932

## SCHOOL OF MEDICINE

**P. B. Wingfield,** 24, of Yellow Springs, Ohio retired July 1, after 53 years of medical practice. In 1944 Dr. Wingfield and Dr. Menino founded the Yellow Springs Clinic. In 1974 the Ohio State Medical Association awarded Dr. Wingfield a "Certificate of Distinction in recognition of his devotion to his patients, his contribution to the health and welfare of the public and his allegiance to the principles of the medical profession." The Wingfields hope to spend time caring for his flowers and spending the winters in Florida.

**Isadore I. Kolman,** 38, of Salinas, Ca. writes that he is working in retirement as part-time student health physician, San Jose State University, San Jose Ca.

**Curtis H. Carter,** 38, has been named dean emeritus of the school of medicine at the Medical College of Georgia.

**John H. Robinson, III,** 38, of Americus was recently honored by several members of the Board of Regents of the University System of Georgia. They initiated a scholarship fund at Georgia Southwestern College to pay tribute to fellow Regent Robinson. Dr. Robinson was named to his seven-year term on the Board of Regents in 1972 by Governor Carter. He had been President Carter's personal physician for a number of years.

**Lane Harris Allen,** 39, was named professor emeritus of anatomy at the Medical College of Georgia by the Board of Regents, effective July 1, 1977.

**Asa Daniel Duggan,** 40, of Washington has been named a diplomate of the ABFG.

**Robert Perry,** 44, is on the board of the State Medical Education Board.

**H. Calvin Jackson,** 45, of Manchester was re-elected Chairman of the State Medical Education Board.

**William A. Dodd,** 47, President of the Georgia Association of Nursing Home Medical Directors, recently addressed the members of the governing council of the American Health Care Association.

**David A. Wells,** 49, of Whitfield County, was appointed by Governor George Busbee to the State Medical Education Board.

**George B. Fisher,** 50, was honored by the Heard County Board of Health for 25 years of dedicated service to the people of that county. He was Chief of the Medical Staff at the Heard County Memorial Hospital and served as County Physician for 20 years.

**C. Denton Johnson,** 51, of Columbus has been named a diplomat of the ABFP.

**John W. Acree,** 53, of Hiawassee has been named to the State Board of Human Resources. He is to fill the unexpired term of Dr. Pittard of Toccoa. Acree's appointment runs through April 6, 1978.

**Harry L. Cheves,** 53, has been elected to serve as President of the Southern District Medical Society.

**Stephen C. May, Jr.,** 56, was recently sworn in as a member of the Joint Advisory Board of Family Practice, a board created by last year's legislature.

**William McCall Calhoun,** 58, of Buena Vista was named Chief of Staff at the Steward-Webster Hospital, Richland.

**E. R. Hensley,** 59, of Waynesboro was named a diplomat of the American Board of Family Practice.

**Paul Payne,** 59, orthopedic surgeon, was one of the newly elected officers of the Kennestone Hospital Medical Staff. He began his term as Medical Staff Secretary on July 1.

**James W. Vandiver,** 59, has been named clinical assistant professor of surgery (neurosurgery) at Emory Medical School. He is in practice in Decatur, Ga.

**Donald Gilmer,** 64, has been elected to Fellowship in The American Academy of Allergy.

**Alfred M. Holloway Jr.,** 64, of Thomaston has been named a diplomat of the ABFP.

**Ronald S. Gable,** 65, of Nashville, Tenn. has been certified by the American Board of Ophthalmology. He has joined the faculty at Vanderbilt University as an instructor in the Department of Ophthalmology. He and his wife, Dianne, have two children, Alicia, 5 and Ashley, 2.

**Scott MacLeod,** 66, of Rome was elected to fellowship in the American College of Cardiology.

**Marvin Skelton,** 66, who is presently practicing radiology at the Memorial Medical Center in Savannah, will be moving to the Brunswick area to work with the Brunswick Radiologists. He has joined the staff at Glenn Brunswick Memorial Hospital.

**C. Neil Kelley,** 66, has been elected president of the Georgia Lung Association's Northeast Branch Advisory Board. He also serves as a member of the State Board of Directors of the Georgia Lung Association.
**Sidney Bell,** 67, orthopedic surgeon has been named to Redmond Park Hospital's Board of Trustees. Dr. Bell is associated with Harbin Clinic and is on the staff at Floyd Hospital.
**Fred Gilliard,** 68, of Douglas has been named a diplomat of the ABFP.
Navy Medical Corps Lieutenant Commander **James C. Baggett Jr.,** 69, has completed Navy Flight Surgeon training at the Naval Aerospace Medical Institute, Pensacola, Fl. He will report for duty with Reconnaissance Squadron I, Agana, Guam.
**James C. Pope,** 69, finished his tour in the U.S. Army and is returning to Memphis, Tenn. for a 1 year fellowship in peripheral vascular surgery.
**James C. Sikes,** 71, will enter practice of Psychiatry with his father, **Z. Sweeney Sikes Jr.,** 38, in Macon.
**James Pilcher Jr.,** 71, native of Louisville, Ga. and **James Blackwell,** 74, of Carrollton began practice July 1 in Dalton, Ga. Dr. Pilcher will practice internal medicine and rheumatology, Dr. Blackwell will be engaged in internal medicine. Dr. and Mrs. Pilcher are the parents of two children, Sarah, four and Paul, 18 months-old. Dr. and Mrs. Blackwell have a son, Matthew, three months old.
**Joseph B. LeRoy,** 72, will join the faculty at the University of Louisville as Assistant Professor of Psychiatry.
**Ed Wysong,** 72, announced the partnership of **Glenn Bartlett,** 75, of Decatur. Dr. Bartlett comes from LaFayette where he has been practicing for several years.
**Dr. Jim Scott,** 72, joined **Dr. Gerald Sapp,** 65, in the practice of orthopedic medicine at Tifton.
**Mary H. Hahder,** 72, has been appointed assistant professor in the Department of Gynecology-Obstetrics at Emory University School of Medicine.
**Stephen G. Godlewski,** 73, an opthalmologist, will open an office in Gainesville this August.
**Louis Weinstein,** 73, has been notified that he is a diplomat of the American Board of Radiology. Dr. Weinstein will be doing a one year fellowship at Vanderbilt Medical School and he will be serving on the faculty during his fellowship training.
**Carl Bedingfield,** 74, has begun his practice of pediatrics in association with **Dr. Nelson Carswell,** 56, in Dublin. Dr. Bedingfield and his wife have three children, Julia, 2 and twins, Carla and Jennifer, six months.
**Gregory V. Smith,** 74, entered the practice of pediatrics in Gainesville, Ga. He and his wife have two-year old twin sons, Will and Robbie.
**Hubert (Randy) Smith,** 74, opened an office for the practice of family medicine in Statesboro.
**Kim Meadors,** 76, and **Richard Miller,** 76, will open their practice in Banks County. Both doctors are part of a Health Education and Welfare program. They chose the National Health Service Corps, under which they must serve for three years.
**Sidney Jospeh Morgan Jr.,** 77, has assumed a residency in family practice in Spartanburg, S.C.

## SCHOOL OF ALLIED HEALTH SCIENCE

### Medical Illustration

**Ed Hard,** 68, has accepted a position as media director of a 30-man unit at the University of Texas Medical Branch in Galveston.

### Medical Technology

**Ann Stuart Anderson,** 67, has been appointed Chairman of the Department of Medical Technology at Medical College of Georgia.
**Annie Ruth Winningham,** 68, Associate Professor in the Department of Medical Technology at MCG, was named Medical Technologist of the Year in the State of Georgia.
**Marilyn Kanegelos,** 65, former Associate Professor in the Department of Medical Technology, has accepted a position in the Medical Technology program, Department of Allied Health Sciences, Florida Technological University, Orlando, Fl.

### Occupational Therapy

**Donna Luanne Jones,** 77, has accepted a position as staff therapist in the Department of Occupational Therapy at the Georgia Warm Springs Hospital.

### Physician's Assistant

**U. Randall Rhiner,** 76, and his wife are living in Covington, GA. where he is working with Dr. E. J. Callaway.

### Physical Therapy

**Carol Anne McLarty,** 76, has joined the staff as full-time therapist at Northeast Georgia Medical Center.
**Dianne Fay Simmons,** 77, will be working at Coliseum Park Hospital in Macon.

## SCHOOL OF DENTISTRY

**Philip E. Koch,** 74, has established his practice of oral surgery in Gainesville, Ga.
**Dale Madson,** 76, a general practice dentist, has opened an office in Statesboro. He and wife have a 18-month-old-son.

## SCHOOL OF NURSING

**Jacolyn I. Murphy,** 58, is a major in the U.S. Air Force Corps after 15 years of active duty. She is a Pediatric Nurse Practitioner and is presently stationed at the Scott AFB Medical Center in Ill.
**Lynn McKneely Garnard,** 70, and her husband, Thurston, announce the birth of their first child, Laura Lynn, born February 10, 1977.
**Brenda J. McAvory,** 71, of East Point has been named director of Nursing Division at LaGrange College. She has been named to the World Who's of Women in Education.
**Sharon Lynn Hall,** 75, will assume her duties as instructor in nursing at the University of Mississippi School of Nursing.
**Melinda McLemore,** 76, nursing supervisor with the Glynn County Health Department, presented Workshop I, Assertiveness Training for Women as a part of Spring Quarter at the YWCA.

## SCHOOL OF GRADUATE STUDIES

**Bill Winn,** 66, associate professor and co-chairman of medical illustration at The University of Texas Health Science Center at Dallas, designed the award-winning exhibit at the American Medical Association annual convention.

Schools of Medicine Allied Health Sciences Graduate Studies Nursing Dentistry

MCG Today

Medical College of Georgia
Division of Institutional Relations
Augusta, Georgia 30901

Second Class
Postage Paid at
Augusta, Georgia